AMENDED IN SENATE JUNE 12, 2002

AMENDED IN SENATE JULY 5, 2001

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AMENDED IN ASSEMBLY MARCH 27, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL No. 424

Introduced by Assembly Member ~~Aroner~~ *Thomson*

February 20, 2001

~~An act to amend Section 1371.4 of the Health and Safety Code, relating to health care.~~ *An act to amend Sections 12670, 12671, and 12678 of, and to add Section 12692.5 to, the Insurance Code, relating to health insurance.*

LEGISLATIVE COUNSEL'S DIGEST

AB 424, as amended, ~~Aroner~~ *Thomson.* Health ~~care: emergency services~~ *insurance: conversion coverage.*

Existing law imposes requirements relating to the obligation of a health insurance issuer to provide coverage through a converted policy to certain individuals after they become ineligible for coverage through a group plan. Under existing law, these requirements pertain to a group

health insurance policy issued, amended, or renewed on or after January 1, 1983.

This bill would specify that certain existing requirements to provide coverage through a converted policy do not apply to a group policy that is issued, amended, or renewed on or after June 1, 2003. The bill would provide that its provisions would become operative on June 1, 2003, only if this bill and AB 1401 are both enacted before January 1, 2003.

~~Existing law, the Knox-Keene Health Care Service Plan Act or 1975, requires that health care service plans reimburse providers for emergency services and care without prior authorization in specified circumstances and provides procedures for obtaining authorization and resolving disagreements in circumstances where, in the opinion of the emergency or attending physician, or other provider, a patient who has received emergency care may not be safely discharged.~~

~~This bill would provide that a provider of emergency services treating an enrollee of a health care service plan should contact the plan's system in order to obtain information about the enrollee if that system meets certain requirements. The bill would prohibit a provider who did not contact the system prior to admission from billing either the enrollee or the health care service plan for medical services rendered following the enrollee's stabilization. The bill would provide that these requirements do not apply if the provider was unable to obtain the name of the enrollee's health plan.~~

~~Because a violation of this bill's prohibition against a provider of emergency services billing enrollees or health care services plans in specified circumstances would be a crime, the bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~yes~~ *no*. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1371.4 of the Health and Safety Code is~~

SECTION 1. Section 12670 of the Insurance Code is amended to read:

12670. It is the intent of the Legislature to ensure that persons covered by a group policy, who become ineligible for ~~such~~ *that* coverage have access to ~~minimum~~ benefits pursuant to this part by requiring employers, employee organizations, and other entities ~~which~~ *that* provide ~~such~~ *that* coverage to their employees or members to also make available conversion policies for ~~such~~ *those* persons and to ensure that insurers as herein defined offer conversion policies. *The conversion policies shall be the two most popular products offered to residents of this state under the provisions of the federal Health Insurance Portability and Accountability Act of 1996.* In addition, it is the intent of the Legislature to encourage the continuation of group health coverage by requiring the entities herein defined to make available continuation benefits for widows, widowers, divorced spouses, and dependents who were covered by the group policy on the date of termination of coverage.

SEC. 2. Section 12671 of the Insurance Code is amended to read:

12671. As used in this part:

(a) ''Group policy'' means a group ~~disability~~ *health* insurance policy providing medical, hospital, surgical, major medical, or comprehensive medical coverage issued by an insurer, a group contract issued by a hospital service corporation or medical, hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members, except for self-insurance programs provided by employers that are not exempt from ERISA, as specified in subdivision (i). For the purposes of this part, a group policy not having an established annual renewal date shall be considered renewed on each anniversary of its effective date.

(b) ''Conversion coverage'' means ~~disability~~ *health* insurance benefits providing hospital, surgical, major medical, or comprehensive medical coverage issued to an individual under a converted policy.

(c) ''Converted policy'' means a policy or contract providing conversion coverage issued by an insurance company or by a hospital service corporation, or individual hospital, surgical,

major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members.

(d) ''Insurer'' means the entity issuing a group policy, an individual or converted policy, a hospital service contract or an employer or employee organization otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage to its employees or members.

(e) ''Insurance'' refers to medical, hospital, surgical, major medical, or comprehensive coverage paid by premium or contribution under a group policy, a hospital service contract, or as otherwise provided by a policyholder to its employees or members other than by self-insuring except in the case of a plan that is exempt from ERISA, but does include an employer plan that is exempt from ERISA as specified in subdivision (i). ''Insurance'' does not include coverage provided solely as an accrued liability or by reason of a disability extension.

(f) ''Policyholder'' means the holder of a group policy issued by an insurer, a holder of a group contract issued by a hospital service corporation or an employer, employee association or other entity otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage on a group basis to its employees or members.

(g) ''Premium'' means contribution or other consideration paid or payable for coverage under a group policy or converted policy.

(h) ''Medicare'' means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(i) ''Employer plan that is exempt from ERISA'' means any employer plan that, pursuant to the provisions of Section 1003 of Title 29 of the United States Code, is not covered by or that is exempt from the provisions of Subchapter I (commencing with Section 1001) of Chapter 18 of Title 29 of the United States Code, except that, in the case of a governmental plan, it only includes a self-insured governmental plan as defined in subdivision (h).

~~(h)~~

(j) ''Self-insured governmental plan'' means a self-insured plan established or maintained for its employees by any public entity, as defined in Section 811.2 of the Government Code, which is a governmental plan as defined in subdivision (32) of Section 1002 of Title 29 of the United States Code.

SEC. 3. Section 12678 of the Insurance Code is amended to read:

12678. The insurer shall not be required to issue a converted policy covering any person if any of the following exists:

(a) ~~Such~~ *The* person is covered for similar benefits by another individual policy.

(b) ~~Such~~ *The* person is covered or is eligible to be covered for similar benefits by another group policy.

(c) ~~Such~~ *The* person is covered or is eligible to be covered for similar benefits under any arrangement of coverage for persons in a group whether insured or uninsured.

~~(d) Similar benefits are provided for or are available to such person, by reason of any state or federal law.~~

~~(e) As used in this section, ''state or federal law'' does not include Chapter 7 (commencing with Section 14000) of Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Title XIX of the United States Social Security Act.~~

SEC. 4. Section 12692.5 is added to the Insurance Code, to read:

12692.5. Notwithstanding any other provision of this part, Sections 12672, 12673, 12674, 12675, 12676, 12677, 12678, 12679, 12680, 12681, 12682, 12683, 12684, 12685, 12686, 12687, 12688, 12689, 12690, 12691, and 12692 shall not apply to a group policy that is issued, amended, or renewed on or after June 1, 2003.

SEC. 5. This act shall become operative on June 1, 2003, only if this act and Assembly Bill 1401 of the 2001–02 Regular Session are both enacted before January 1, 2003.

~~amended to read:~~

~~1371.4. (a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an~~

~~emergency medical condition or active labor need not satisfy the requirements of this subdivision.~~

~~(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.~~

~~(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed, provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.~~

~~(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.~~

~~(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.~~

~~(f) Subdivisions (b), (c), (d), (h), and (i) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.~~

~~(g) If an enrollee's health plan provides a system that includes (1) availability by telephone within 30 minutes of a practicing emergency physician with sufficient access to the enrollee's records so that the diagnostic and other medical information can be transmitted to the treating emergency provider telephonically, electronically, or by facsimile machine, and (2) ability to provide information concerning copayments that a nonparticipating hospital may charge the health plan enrollee, the provider of emergency services treating an enrollee of that health plan should contact that system as soon as possible. If the provider of emergency services in California, or a representative of the provider, does not contact the system to obtain information about the enrollee contained in the medical records prior to admitting the enrollee into the nonparticipating hospital or prior to transferring that patient to a nonparticipating hospital, that provider may not bill either the enrollee or the health care service plan for medical services provided following stabilization. This section shall not apply when the provider was not able to obtain the name of the enrollee's health plan.~~

~~(h) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.~~

~~(i) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.~~

~~(j) The definitions set forth in Section 1317.1 shall control the construction of this section.~~

~~SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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